SENATE BILL No. 204

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-13.5; IC 27-13; IC 27-17.

Synopsis: Health coverage options. Allows, under certain circumstances, an accident and sickness insurer or a health maintenance organization to provide a policy or contract without complying with all health benefit mandates. Authorizes health benefit purchasing cooperatives. Requires insurers and health maintenance organizations to report specified information concerning the policies and contracts to the department of insurance. Requires the department to report to the legislative council.

Effective: July 1, 2006.

Drozda

January 9, 2006, read first time and referred to Committee on Health and Provider Services.

Introduced

Second Regular Session 114th General Assembly (2006)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2005 Regular Session of the General Assembly.

SENATE BILL No. 204

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]:

Chapter 13.5. Health Benefit Mandate Option

Sec. 1. As used in this chapter, "health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, a policy of accident and sickness insurance, to the extent that the coverage is not required under federal law:

(1) Newborn coverage under IC 27-8-5.6.

(2) Breast cancer screening related coverage under IC 27-8-14.

(3) Morbid obesity related coverage under IC 27-8-14.1.

(4) Pervasive developmental disability related coverage under IC 27-8-14.2.

(5) Diabetes related coverage under IC 27-8-14.5.

(6) Prostate cancer screening related coverage under

IC 27-8-14.7.

(7) Colorectal cancer screening related coverage under IC 27-8-14.8.

(8) Off label drug treatment coverage under IC 27-8-20.

(9) Minimum maternity related benefits under IC 27-8-24.

(10) Inherited metabolic disease related coverage under IC 27-8-24.1.

(11) Mastectomy related coverage under IC 27-8-5-26.

(12) Mental illness related coverage under IC 27-8-5-15.6.

(13) Dental anesthesia related coverage under IC 27-8-5-27.

(14) Adopted child coverage under IC 27-8-5-21.

Sec. 2. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3(x)) that issues or delivers a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 4. As used in this chapter, "prospective purchaser" means an:

(1) individual who requests coverage under a policy of accident and sickness insurance that is issued on an individual basis; or

(2) employer that:

(A) employs not more than fifty (50) employees, a majority of whom were not offered coverage for health care services (as defined in IC 27-13-1-18) by:

(i) the employer; or

(ii) a parent, a subsidiary, or an affiliate of the employer;

during the preceding calendar year; and

(B) requests coverage for the employer's employees under a policy of accident and sickness insurance that is issued on a group basis.

Sec. 5. Notwithstanding any other law, an insurer may offer to a prospective purchaser a policy of accident and sickness insurance without complying with all health benefit mandates if:

(1) when the offer is made, the insurer provides a list of the health benefit mandates with which the offer does not comply; and

(2) the policy offered includes the following:

(A) Newborn coverage required under IC 27-8-5.6.

(B) Diabetes related coverage required under IC 27-8-14.5.

(C) If the prospective purchaser is described in section 4(2) of this chapter:

(i) breast cancer screening related coverage required under IC 27-8-14;

(ii) prostate cancer screening related coverage required under IC 27-8-14.7; and

(iii) colorectal cancer screening related coverage required under IC 27-8-14.8.

(D) Adopted child coverage required under IC 27-8-5-21.

(E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).

Sec. 6. An insurer that offers to a prospective purchaser a policy of accident and sickness insurance described in section 5 of this chapter shall also offer to the prospective purchaser a policy of accident and sickness insurance in compliance with all health benefit mandates.

Sec. 7. An insurer that issues or delivers a policy of accident and sickness insurance described in section 5 of this chapter shall provide to an individual insured under the policy of accident and sickness insurance a written disclosure that:

(1) acknowledges that the policy of accident and sickness insurance is not issued in compliance with all health benefit mandates; and

(2) lists in summary form the health benefits:

(A) to which a health benefit mandate applies; and

(B) for which coverage is provided in the policy of accident and sickness insurance.

SECTION 2. IC 27-13-1-17.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]: **Sec. 17.6. "Health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, an individual contract or a group contract, to the extent that the coverage is not required under federal law:**

(1) Newborn coverage under IC 27-8-5.6.

(2) Breast cancer screening related coverage under IC 27-13-7-15.3.

(3) Morbid obesity related coverage under IC 27-13-7-14.5.

(4) Pervasive developmental disability related coverage under IC 27-13-7-14.7.

(5) Diabetes related coverage under IC 27-8-14.5.

(6) Prostate cancer screening related coverage under IC 27-13-7-16.

(7) Colorectal cancer screening related coverage under IC 27-13-7-17.

(8) Off label drug treatment coverage under IC 27-8-20.

(9) Minimum maternity related benefits under IC 27-8-24.

(10) Inherited metabolic disease related coverage under IC 27-13-7-18.

(11) Mastectomy related coverage under IC 27-13-7-14.

(12) Mental illness related coverage under IC 27-13-7-14.8.

(13) Dental anesthesia related coverage under IC 27-13-7-15.

(14) Adopted child coverage under IC 27-8-5-21.

SECTION 3. IC 27-13-1-27.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]: **Sec. 27.8. "Prospective purchaser" means an:**

(1) individual who requests coverage under an individual contract; or

(2) employer that:

(A) employs not more than fifty (50) employees, a majority of whom were not offered coverage for health care services by:

(i) the employer; or

(ii) a parent, a subsidiary, or an affiliate of the employer; during the preceding calendar year; and

(B) requests coverage for the employer's employees under a group contract.

SECTION 4. IC 27-13-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]:

Chapter 7.5. Health Benefit Mandate Option

Sec. 1. Notwithstanding any other law, a health maintenance organization may offer to a prospective purchaser an individual contract or a group contract without complying with all health benefit mandates if:

(1) when the offer is made, the health maintenance organization provides a list of the health benefit mandates with which the offer does not comply; and

(2) the contract offered includes the following:

(A) Newborn coverage that is substantially similar to the coverage required under IC 27-8-5.6.

(B) Diabetes related coverage required under IC 27-8-14.5.

(C) If the prospective purchaser is described in IC 27-13-1-27.8(2):

(i) breast cancer screening related coverage required under IC 27-13-7-15.3;

(ii) prostate cancer screening related coverage required under IC 27-13-7-16; and

(iii) colorectal cancer screening related coverage required under IC 27-13-7-17.

(D) Adopted child coverage required under IC 27-8-5-21.

(E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).

Sec. 2. A health maintenance organization that offers to a prospective purchaser an individual contract or a group contract described in section 1 of this chapter shall also offer to the prospective purchaser an individual contract or a group contract in compliance with all health benefit mandates.

Sec. 3. A health maintenance organization that enters into or delivers an individual contract or a group contract described in section 1 of this chapter shall provide to an enrollee a written disclosure that:

(1) acknowledges that the individual contract or group contract is not entered into in compliance with all health benefit mandates; and

(2) lists in summary form the health benefits:

(A) to which a health benefit mandate applies; and

(B) for which coverage is provided in the individual contract or group contract.

SECTION 5. IC 27-17 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]:

ARTICLE 17. HEALTH BENEFIT PURCHASING COOPERATIVES

Chapter 1. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. "Board" refers to the board of directors elected by a cooperative.

Sec. 3. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 4. "Covered individual" means an individual covered under a health benefit plan provided through a health benefit purchasing cooperative.

Sec. 5. (a) "Eligible employee" means an individual who works

for a single employer at least thirty (30) hours per week.

(b) The term includes:

(1) a sole proprietor;

(2) a partner; and

(3) an independent contractor;

if the individual is considered an employee under an employer health benefit plan.

(c) The term does not include an employee who:

(1) works on a part-time, temporary, seasonal, or substitute basis;

(2) is covered under:

(A) another health benefit plan; or

(B) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.); or

(3) elects not to be covered under the employer's health benefit plan and is covered under:

(A) the Medicaid program under IC 12-15;

(B) another federal program, including Medicare (42 U.S.C. 1395 et seq.); or

(C) a health benefit plan established in another country.

Sec. 6. "Employer health benefit plan" means a health benefit plan issued or delivered to cover the employees of an employer.

Sec. 7. (a) "Health benefit plan" means the following:

(1) A group policy or a certificate of coverage under a group policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A health maintenance organization group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:

(1) Accident only insurance.

(2) Credit only insurance.

(3) Disability insurance or disability income insurance.

(4) Medicare (42 U.S.C. 1395 et seq.), a Medicare supplement, or a Medicare select benefit plan regulated under federal law.

(5) Long term care insurance, nursing home care insurance, home health care insurance, or community based care insurance.

(6) Limited scope dental or vision insurance.

(7) Workers' compensation insurance.

(8) Coverage provided through a jointly managed trust

authorized under 29 U.S.C. 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of employees that is authorized under 29 U.S.C. 157.

(9) Hospital indemnity or other fixed indemnity insurance.

(10) Reinsurance contracts issued on a stop loss, quota share, or similar basis.

(11) Short term major medical contracts.

(12) Liability insurance, including general liability insurance and automobile liability insurance, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance.

(13) Coverage for onsite medical clinics.

(14) Coverage that provides other limited benefits specified by federal regulation.

(15) Other coverage that:

(A) is similar to the coverage described in this subsection under which benefits for medical care are secondary or incidental to other coverage benefits; and

(B) is specified by federal regulations.

Sec. 8. "Health benefit plan issuer" means an entity authorized under IC 27 to issue or deliver a health benefit plan in Indiana.

Sec. 9. "Health status related factor" means:

(1) health status;

(2) medical condition, including mental and physical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability, including conditions arising out of acts of family violence; and

(8) disability.

Sec. 10. "Insurance producer" has the meaning set forth in IC 27-1-15.6-2.

Sec. 11. (a) "Large employer" means a person, including a governmental entity, that:

(1) employs at least two (2) eligible employees on the first day of the plan year; and

(2) employed an average of at least fifty-one (51) eligible employees on business days during the preceding calendar

year.

(b) For purposes of this section, a partnership is the employer of a partner.

Sec. 12. "Large employer health benefit plan" means a health benefit plan offered to a large employer.

Sec. 13. "Person" means an individual or a business entity.

Sec. 14. "Premium" means amounts paid by an employer and eligible employees as a condition of receiving coverage from a health benefit plan issuer, including fees or other contributions associated with a health benefit plan.

Sec. 15. "Private purchasing cooperative" means a group of two (2) or more employers that forms to purchase coverage under an employer health benefit plan.

Sec. 16. (a) "Small employer" means a person, including a governmental entity, that:

(1) employs at least two (2) eligible employees on the first day of the plan year; and

(2) employed an average of at least two (2) eligible employees and not more than fifty (50) eligible employees on business days during the preceding calendar year.

(b) For purposes of this section, a partnership is the employer of a partner.

Sec. 17. "Small employer health benefit plan" means a health benefit plan offered:

(1) in compliance with IC 27-8-15; and

(2) to a small employer.

Chapter 2. Establishment of a Health Benefit Purchasing Cooperative

Sec. 1. Two (2) or more:

(1) small employers; or

(2) large employers;

may form a health benefit purchasing cooperative to purchase coverage under a small employer health benefit plan or a large employer health benefit plan. A small employer and a large employer may not participate in the same health benefit purchasing cooperative.

Sec. 2. A health benefit purchasing cooperative established under section 1 of this chapter must be organized as a nonprofit corporation under IC 23-17.

Sec. 3. Upon receipt from the secretary of state of notice that a health benefit purchasing cooperative's articles of incorporation have been filed under IC 23-17-3, the health benefit purchasing

cooperative shall file with the commissioner:

(1) written notice of the receipt of the notice from the secretary of state; and

(2) a copy of the health benefit purchasing cooperative's organizational documents.

Sec. 4. A health benefit purchasing cooperative's board shall annually file with the commissioner a statement of amounts collected and expenses incurred by the health benefit purchasing cooperative for each of the three (3) preceding years.

Chapter 3. Immunity

Sec. 1. A health benefit purchasing cooperative or a member of the board, the executive director, or an employee or agent of a health benefit purchasing cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the health benefit purchasing cooperative; or

(2) an independent action of a health benefit plan issuer or a person who provides health care services under a health benefit plan.

Chapter 4. Functions of a Health Benefit Purchasing Cooperative

Sec. 1. A health benefit purchasing cooperative shall:

(1) arrange, by contracting with health benefit plan issuers that meet the requirements of IC 27-17-5, for:

(A) small employer health benefit plan coverage for small employer groups; or

(B) large employer health benefit plan coverage for large employer groups;

that participate in the health benefit purchasing cooperative;

(2) collect premiums to cover the cost of:

(A) health benefit plan coverage purchased through the health benefit purchasing cooperative; and

(B) the health benefit purchasing cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the health benefit purchasing cooperative;

(4) establish procedures under which an applicant for or participant in coverage issued through the health benefit purchasing cooperative may have a grievance reviewed by an impartial person;

(5) contract with health benefit plan issuers to provide services to participating employers; and

(6) develop and implement a plan to maintain public

awareness of the health benefit purchasing cooperative and publicize the:

(A) eligibility requirements for; and

(B) procedures for enrollment in;

coverage through the health benefit purchasing cooperative.

Sec. 2. A health benefit purchasing cooperative may:

(1) contract with a health benefit plan issuer or a third party administrator to provide administrative services to the health benefit purchasing cooperative;

(2) negotiate premiums paid by a participating employer; and

(3) obtain for participating employers ancillary products and services that are customarily offered in conjunction with a health benefit plan.

Sec. 3. A health benefit purchasing cooperative may not limit, restrict, or condition an employer's or employee's participation in a health benefit purchasing cooperative, or choice among health benefit plans, based on:

(1) risk characteristics; or

(2) health status related factors, duration of coverage, or a similar characteristic related to the health status or experience;

of a group or a member of a group.

Sec. 4. A health benefit purchasing cooperative may not self-insure or self-fund a health benefit plan or part of a health benefit plan.

Sec. 5. A health benefit purchasing cooperative shall comply with federal and state laws that apply to:

(1) the health benefit purchasing cooperative; and

(2) a health benefit plan issued through the health benefit purchasing cooperative.

Chapter 5. Health Benefit Plan Issuers

Sec. 1. A health benefit purchasing cooperative may contract only with a health benefit plan issuer that desires to offer coverage through the health benefit purchasing cooperative and that demonstrates that the health benefit plan issuer:

(1) is in good standing with the department of insurance;

(2) has the capacity to administer a health benefit plan;

(3) is able to monitor and evaluate the quality and cost-effectiveness of health care services and procedures;

(4) is able to perform utilization management and establish utilization management policies and procedures;

(5) is able to ensure that covered individuals have adequate

access to health care providers, including adequate numbers and types of health care providers;

(6) has a satisfactory grievance procedure and is able to respond to the calls, questions, and complaints of covered individuals; and

(7) has financial capacity, either through:

(A) satisfying financial solvency standards applied by the commissioner; or

(B) appropriate reinsurance or other risk-sharing mechanisms.

Sec. 2. A health benefit plan issuer:

(1) may:

(A) elect not to provide coverage for a health benefit purchasing cooperative;

(B) provide coverage for one (1) or more health benefit purchasing cooperatives; and

(C) select the health benefit purchasing cooperatives for which the health benefit plan issuer provides coverage; and

(2) may not be a participating employer of a health benefit purchasing cooperative.

Chapter 6. Status as Employer

Sec. 1. (a) Except as provided in subsection (b), a health benefit purchasing cooperative is considered an employer solely for the purpose of benefit elections under this article.

(b) A group of small employers that:

(1) forms a health benefit purchasing cooperative;

(2) employs a total of at least two (2) eligible employees on the first day of the plan year; and

(3) employed an average total of at least two (2) eligible employees and not more than fifty (50) eligible employees on business days during the preceding calendar year;

is considered a single small employer for purposes of this article and IC 27-8-15.

(c) A group of small employers that:

(1) forms a health benefit purchasing cooperative;

(2) employs at least two (2) eligible employees on the first day of the plan year; and

(3) employed an average total of more than fifty (50) eligible employees on business days during the preceding calendar year;

is considered a large employer for purposes of this article and IC 27-8-15.

Chapter 7. Miscellaneous

Sec. 1. IC 27-8-5-16 does not limit the type of group that may be covered by a health benefit plan issued through a health benefit purchasing cooperative.

Sec. 2. (a) An employer's participation in a health benefit purchasing cooperative is voluntary.

(b) Except as provided in the rules adopted under subsection (c), an employer that participates in a health benefit purchasing cooperative shall purchase health benefit plan coverage through the health benefit purchasing cooperative for at least two (2) years.

(c) The commissioner shall adopt rules under IC 4-22-2 to provide for a participating employer's termination of participation in a health benefit purchasing cooperative if the participating employer experiences a financial hardship.

Sec. 3. An insurance producer or third party administrator that provides services to and is compensated by a health benefit purchasing cooperative must be licensed as required under IC 27.

SECTION 6. [EFFECTIVE JULY 1, 2006] **(a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.**

(b) An insurer that issues or delivers a policy of accident and sickness insurance described in IC 27-8-13.5-5, as added by this act, and a health maintenance organization that enters into or delivers a contract described in IC 27-13-7.5-1, as added by this act, shall report the following information to the department not later than November 15, 2007:

(1) The number of policies described in this subsection that are issued or delivered by the insurer and the number of individuals covered under each policy.

(2) The number of contracts described in this subsection that are entered into or delivered by the health maintenance organization and the number of individuals covered under each contract.

(3) The premium charged for each policy or contract described in this subsection.

(4) The difference between:

(A) the premium charged for each policy or contract described in this subsection; and

(B) the premium that would be charged for any other policy or contract offered by the insurer or health maintenance organization to a prospective purchaser that purchased a policy or contract described in this subsection.

(c) Not later than December 1, 2007, the department shall compile the information reported to the department under subsection (b) and report the information to the legislative council in an electronic format under IC 5-14-6. The department:

(1) shall include in the report information concerning the number of uninsured individuals in Indiana; and

(2) may include any other information in the report that the department determines is relevant.

(d) This SECTION expires December 31, 2007.